STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006761	A. BUILDING: _____ B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPE CREEK NURSING & REHAB	4343 KENNEDY DRIVE EAST MOLINE, IL 61244

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Annual Licensure Health Survey	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210c 300.1210d)6 Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 resident to meet the total nursing and personal care needs of the resident. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. These Requirements were NOT MET as evidenced by: Based on interview and record review, the facility failed to investigate and determine a root cause analysis of a fall, failed to implement fall interventions, and failed to provide supervision during toileting to prevent a fall for one of five residents (R120) and failed to monitor a personal safety monitoring device for a resident identified as high risk for elopement for one of two residents (R341) reviewed for accidents/incidents in the sample of 64. As a result of this failure R120 fell in the bathroom after being left unattended on the toilet on 05/03/22, and was subsequently transferred to a local hospital and diagnosed with a left femoral neck fracture. Findings include:	S9999		

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S9999	Continued From page 2	S9999		

1. The facility's Incidents/Accidents/Falls policy (undated) documents the following: "It is the policy of the facility to ensure that any incident/accident to include falls is reported immediately to the nurse or appropriate person designated to be in charge. After the resident has had immediate attention and their safety is established, a written report will be entered into Risk Management. The facility will ensure that incidents and accidents that occur involving residents are identified, reported, investigated and resolved. The facility will create a data base related to incidents/accidents as part of the QAPI (Quality Assurance Process Improvement) process to enable trending and tracking. This information will be used to implement corrective actions to include any needed training to prevent recurrences when possible. It will be part of the QAPI (Quality Assurance and Performance Improvement- monthly meeting) Agenda."

R120's Fall Risk Reviews (dated 04/05/22, 04/11/22, and 05/07/22) all document scores greater than 10, indicating R120 is at high risk for falls.

R120's Minimum Data Set Assessment (dated 05/16/22) documents in Section C, Cognitive Patterns, a Brief Interview for Mental Status score of 1, indicating severe cognitive impairment. This same assessment documents in Section G, Functional Status, that R120 requires extensive assistance (resident involved in activity, staff provide weight-bearing support) with two+ persons physical assist with toilet use.

R120's current care plan documents the following fall prevention intervention: "Anticipate and meet the individual needs of the resident."

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R120's Fall Investigation (dated 2/8/22) is blank and does not document the following: a root cause analysis was determined, a care plan review was conducted or new fall prevention intervention was implemented. On 06/30/22 at 10:10 AM, V19 (Minimum Data Set Assessment Coordinator) stated that R120's fall on 2/8/22 was never investigated, and therefore, a root cause of R120's fall was not determined. V19 stated R120's care plan was not reviewed and a new fall prevention intervention was not implemented after R120's 2/8/22 fall. R120's current care plan has no mention of R120's 2/8/22 fall.

R120's Fall Investigation (dated 4/5/22) documents R120 was found on the fall mat next to her bed. On 06/30/22 at 10:14 AM, V19 (Minimum Data Set Assessment Coordinator) stated, "it was found that (R120's) air mattress was not set correctly. It was not set to the correct weight that correlates with what R120 weighs, which may have caused her to roll out of bed. The mattress should have been set to (R120's) current weight at that time."

R120's Fall Investigation (dated 04/20/22) documents R120 fell while attempting to stand unassisted in the dining room. On 06/30/22 at 10:18 AM, V19 (Minimum Data Set Assessment Coordinator) stated the fall prevention intervention to obtain a Depakote level was ordered after R120's 04/20/22 fall, and V19 stated it was never completed.

R120's Fall Investigation (dated 05/03/22) documents that R120 had an unwitnessed fall and was found on the floor in the bathroom next to the toilet, and was sent to a local hospital for evaluation. This same investigation documents

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S9999	Continued From page 4 that R120 was left unattended by a staff member after being placed on the toilet, and was on the floor once staff returned. R120's local hospital medical record (dated 05/03/22) documents R120's results of a CT (Computed Tomography) scan of R120's pelvis as follows: "Nondisplaced linear subcapital femoral neck fracture." On 06/30/22 at 10:24 AM, V19 (Minimum Data Set Assessment Coordinator) stated R120 is a 2:1 assist, and staff should have never left her alone on the toilet. On 06/30/22 at 2:00 PM, V29 (Licensed Practical Nurse) stated she was the nurse working at the time of R120's 05/03/22 fall. V29 stated, "(R120) should not be left alone on the toilet. She is a high fall risk. She even wears a helmet, which should have been the first clue not to leave her unattended. I immediately educated the CNA (Certified Nursing Assistant) after she left her alone. I told her this cannot happen on a dementia unit, and (R120) is just too busy and impulsive of a person to leave alone in the bathroom. (R120) is a person that you just can't leave alone." 2. The facility's Policy and Procedure for Personal Safety Monitoring Devices for Residents at Risk of Elopement (dated 08/12/2011) documents the following: "All residents shall be assessed for behaviors that place them at risk of elopement utilizing an elopement risk assessment upon admission, quarterly, annually and upon significant change of condition. The primary care physician for all residents identified of being at risk of elopement will be notified and	S9999		

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S9999	Continued From page 5 an order will be obtained for a personal safety device. The order for the personal safety device will be written on the Physician's Order Sheet in the resident's medical record. The personal safety device will be applied to the resident according to resident needs. Devices may be applied to any extremity. Residents dependent on wheelchairs for transportation may have devices applied to the chair. A plan of care will be developed for all residents identified to be at risk for elopement. All personal safety devices and exit door alarms will be tested daily to assure that each device and door alarm are functioning properly." R341's Wandering Risk Scale (dated 06/12/22) documents a score of 11, indicating R341 is a high risk for wandering. R341's Elopement Risk Review (dated 06/12/22) documents a score of 16, indicating R341 is a high risk for elopement. R341's Progress Note (dated 6/13/22) documents the following: "(R341) is very confused and angry that she is here. She keeps asking to call the police because we are holding her hostage. Easily redirected for a few minutes. She is also exit seeking every chance she gets. (Personal Safety Monitoring Device) in place to left ankle." On 06/30/22 at 09:25 AM, R341 was sitting at the table in the dining room with a group of residents participating in a bingo activity. An unidentified staff member was providing assistance with the activity. An personal safety monitoring device was in place around R341's left ankle. R341's current Physician's Orders do not have an order for a personal safety monitoring device in	S9999		

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S9999	Continued From page 6 place. R341's current care plan has no mention of R341's personal safety monitoring device. R341's Medication Administration Record and Treatment Administration Record (dated 6/12/22 - 6/30/22) have no mention of any monitoring of 341's personal safety monitoring device. On 06/30/22 at 10:00 AM, V2 (Director of Nursing) confirmed that R341's medical record has no record of monitoring R341's electronic personal safety monitoring device. V2 also confirmed that R341's current care plan has no mention of R341's personal safety monitoring device and stated, "(R341) should have a care plan for this." On 06/30/22 at 12:00 PM, V1 (Administrator) stated that standard practice for an elopement risk is to obtain a physician's order, document daily checks of the personal safety monitoring device on the MAR (medication administration record) or TAR (treatment administration record), and a care plan should be in place noting the elopement risk and personal safety device. V1 confirmed that none of the above mentioned has been completed since R341's admission to the facility on 06/12/22. (A)	S9999		